



Agency Benefits Coordinator Meeting

Cancel Request Form & SQE

August 2018

Special Enrollment Provisions

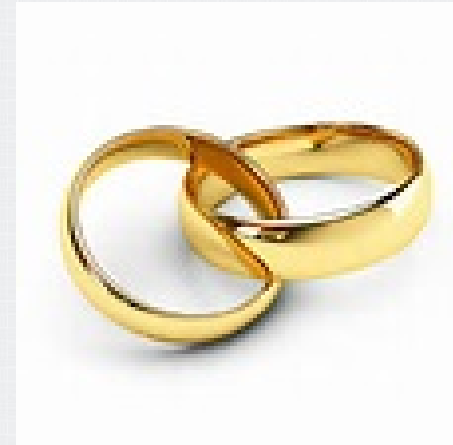
- Defined: The federal law, HIPAA, allows employees and dependents to enroll in coverage under certain conditions outside the annual Open Enrollment Period.

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**things you should know about
Special Enrollment
Provisions**

Life Events

- Life Events are qualifying events that result in adding dependents that are newly eligible. Examples:
 - Marriage Event
 - Birth/Adoption



Special Qualifying Events

Enrollments that are a result of loss of coverage under another plan:



What Forms to Submit?

- Enrollment Change Application: This form should be used to **enroll** or **make changes** to coverage.
- Cancel Request Form: This form should be used to **terminate** coverage.
- Both forms list life event reasons and special qualifying event reasons because the employee is permitted to enroll or cancel under these provisions.
- When enrolling an employee or dependent due to a SQE or Live Event the application must be submitted within 60 days of the event.

Old vs. New: Enrollment Change Application

STATE OF TENNESSEE GROUP INSURANCE PROGRAM
ENROLLMENT CHANGE APPLICATION
 State of Tennessee • Department of Finance and Administration • Benefits Administration
 312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

TYPE OF ACTION	COVERAGE	PARTICIPANTS AFFECTED	REASON FOR THIS ACTION	Life Event	Special Enrollment (also complete pg. 3)
<input type="checkbox"/> Add coverage	<input type="checkbox"/> Health	<input type="checkbox"/> Employee	<input type="checkbox"/> New Hire/Newly Eligible	<input type="checkbox"/> Marriage	<input type="checkbox"/> Death
<input type="checkbox"/> Change coverage	<input type="checkbox"/> Dental	<input type="checkbox"/> Spouse	<input type="checkbox"/> Court Order	<input type="checkbox"/> Newborn	<input type="checkbox"/> Divorce
*Form not for cancellation	<input type="checkbox"/> Vision	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Other _____	<input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Loss of Eligibility
	<input type="checkbox"/> Disability			<input type="checkbox"/> Adoption	

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP: <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov	YOUR CURRENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA		
HOME ADDRESS	<input type="checkbox"/> UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION

SELECT AN OPTION <input type="checkbox"/> Premier PPO <input type="checkbox"/> CDHP/HSA (state) <input type="checkbox"/> Standard PPO	LOCAL ED & GOV ONLY MAY ALSO CHOOSE <input type="checkbox"/> Limited PPO <input type="checkbox"/> Local CDHP/HSA	EMPLOYEE HSA CONTRIBUTION (STATE ONLY) Annual contribution \$ _____	SELECT A CARRIER <input type="checkbox"/> BlueCross BlueShield Network S <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access (surcharge applies)	REGION WHERE YOU LIVE OR WORK <input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West	SELECT A HEALTH PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN <input type="checkbox"/> MetLife DPPO <input type="checkbox"/> Cigna Prepaid DHMO	SELECT A DENTAL PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 5: VISION COVERAGE SELECTION

SELECT A PLAN <input type="checkbox"/> Basic Plan <input type="checkbox"/> Expanded Plan	SELECT A VISION PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 6: DISABILITY SELECTION (ST/NT/TBR)

SHORT TERM DISABILITY <input type="checkbox"/> 60%/14 day Elimination Period <input type="checkbox"/> 60%/30 day Elimination Period	LONG TERM DISABILITY (ST ONLY) <input type="checkbox"/> 60%/90 day Elm Period <input type="checkbox"/> 60%/180 day Elm Period <input type="checkbox"/> 63%/90 day Elm Period <input type="checkbox"/> 63%/180 day Elm Period
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DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

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PARTNERS FOR HEALTH

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<input type="checkbox"/> Change coverage	<input type="checkbox"/> Dental	<input type="checkbox"/> Spouse	<input type="checkbox"/> Termination	<input type="checkbox"/> Newborn	<input type="checkbox"/> Divorce
Terminate coverage	<input type="checkbox"/> Vision	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Court Order	<input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Loss of Eligibility
	<input type="checkbox"/> Disability		<input type="checkbox"/> Other _____	<input type="checkbox"/> Adoption	

PART 2: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY	EMPLOYER GROUP: <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov	YOUR CURRENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA		
HOME ADDRESS	<input type="checkbox"/> UPDATE MY ADDRESS	CITY	ST	ZIP CODE	COUNTY

PART 3: HEALTH COVERAGE SELECTION

SELECT AN OPTION <input type="checkbox"/> Premier PPO <input type="checkbox"/> CDHP/HSA (state) <input type="checkbox"/> Standard PPO	LOCAL ED & GOV ONLY MAY ALSO CHOOSE <input type="checkbox"/> Limited PPO <input type="checkbox"/> Local CDHP/HSA	EMPLOYEE HSA CONTRIBUTION (STATE ONLY) Annual contribution \$ _____	SELECT A CARRIER <input type="checkbox"/> BlueCross BlueShield Network S <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access (surcharge applies)	REGION WHERE YOU LIVE OR WORK <input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West	SELECT A HEALTH PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN <input type="checkbox"/> MetLife DPPO <input type="checkbox"/> Cigna Prepaid DHMO	SELECT A DENTAL PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 5: VISION COVERAGE SELECTION

SELECT A PLAN <input type="checkbox"/> Basic Plan <input type="checkbox"/> Expanded Plan	SELECT A VISION PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren)
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PART 6: DISABILITY SELECTION (ST/NT/TBR)

SHORT TERM DISABILITY <input type="checkbox"/> 14/14 Elimination Period <input type="checkbox"/> 30/30 Elimination Period	LONG TERM DISABILITY (ST ONLY) <input type="checkbox"/> 60%/90 day Elm Period <input type="checkbox"/> 60%/180 day Elm Period <input type="checkbox"/> 63%/90 day Elm Period <input type="checkbox"/> 63%/180 day Elm Period
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Old vs. New: Cancel Request Form



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
INSURANCE CANCEL REQUEST APPLICATION
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STATE OF TENNESSEE GROUP INSURANCE PROGRAM
INSURANCE CANCEL REQUEST APPLICATION
 State of Tennessee • Department of Finance and Administration • Benefits Administration
 312 Rosa L. Parks Avenue • Suite 1900 • Nashville, TN 37243 • Fax: 615.741.8196



NAME		EDISON ID	EMPLOYER GROUP: <input type="checkbox"/> HED <input type="checkbox"/> STATE <input type="checkbox"/> LOCAL ED <input type="checkbox"/> LOCAL GOV
PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)			
I request to cancel <input type="checkbox"/> medical <input type="checkbox"/> dental <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> vision <input type="checkbox"/> FSA/medical <input type="checkbox"/> FSA/dep care <input type="checkbox"/> FSA/limited <input type="checkbox"/> Voluntary AD&D coverage on the participant(s) below due to:			
<input type="checkbox"/> Reason marked in Part 2 below			
<input type="checkbox"/> Prepaid dental; no participating general dentist within a 40-mile radius of my home (skip Parts 2 and 3 below)			
<input type="checkbox"/> Disability; requires 30 days advance written notice (skip Parts 2 and 3 below)			
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) (names):			
INSTRUCTIONS			
You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)			
1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.			
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is received by Benefits Administration.			
The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.			
PART 2 — REASON TO REQUEST TO CANCEL			
REASON	DOCUMENTATION REQUIRED		
<input type="checkbox"/> Marriage, divorce, legal separation, annulment	Copy of marriage certificate or divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above)		
<input type="checkbox"/> Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)		
<input type="checkbox"/> Death of spouse, dependent	Copy of death certificate		
<input checked="" type="checkbox"/> New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status		
<input type="checkbox"/> Entitlement to Medicare, Medicaid, TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card		
<input type="checkbox"/> Court decree or order	Copy of court decree or order signed by judge		
<input type="checkbox"/> Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage		
<input type="checkbox"/> A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address		
<input type="checkbox"/> Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace		
PART 3 — REQUESTED COVERAGE END DATE			
The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.			LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY)

Name		Edison ID	Employer Group: <input type="checkbox"/> UT <input type="checkbox"/> TBR <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov
PART 1 — PARTICIPANT(S) CANCELING COVERAGE (attach a separate sheet if necessary)			
I am requesting to cancel <input type="checkbox"/> medical <input type="checkbox"/> dental <input type="checkbox"/> vision coverage on the participant(s) listed below due to:			
<input type="checkbox"/> Becoming newly eligible for other coverage (mark reason in Part 2 below)			
<input type="checkbox"/> Prepaid dental only; no participating general dentist within 40 miles of my home (skip Parts 2 and 3 below)			
<input type="checkbox"/> Employee	<input type="checkbox"/> Child (provide name):		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Child (provide name):		
INSTRUCTIONS			
You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment transfer period except for one of the following events:			
1. If you and/or your dependent(s) become newly eligible for coverage under another plan (proof is required and only the individual or individuals who become newly eligible for other coverage may cancel). You have 60 days from the date that you and/or your dependent(s) become newly eligible for coverage to submit documentation.			
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is submitted to Benefits Administration.			
The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.			
PART 2 — REASON PARTICIPANT(S) HAS BECOME NEWLY ELIGIBLE UNDER ANOTHER PLAN			
REASON	DOCUMENTATION REQUIRED		
<input type="checkbox"/> Marriage	Copy of marriage certificate and proof of other coverage (see #1 above)		
<input type="checkbox"/> Adoption / placement for adoption	Copy of adoption documents and proof of other coverage (see #1 above)		
<input checked="" type="checkbox"/> New employment (self, spouse or dependent)	Letter, on company letterhead, from employer certifying date of eligibility		
<input checked="" type="checkbox"/> Return from unpaid leave	Letter, on company letterhead, from employer certifying date of return from unpaid leave		
<input type="checkbox"/> Entitlement to Medicare, Medicaid or TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card		
<input type="checkbox"/> Birth	Copy of birth certificate and proof of other coverage (see #1 above)		
<input type="checkbox"/> Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge and proof of other coverage (see #1 above)		
<input type="checkbox"/> Court decree or order	Copy of court decree or order signed by judge		
<input type="checkbox"/> Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage		
<input type="checkbox"/> A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address		
<input type="checkbox"/> From part-time to full-time employment (spouse or dependent)	Letter, on company letterhead, from employer certifying change in status		
<input type="checkbox"/> Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace		
PART 3 — REQUESTED COVERAGE END DATE			
The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.			Last day coverage to be active (mm/dd/yy)

Questions?

